Clinical Practice Summary
For Palliative Care Symptoms
North West Coast Strategic Clinical Network
Cheshire & Merseyside Audit and Clinical Guidelines Group
June 2017
## Contents

### Guidance

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The guidelines on which these Clinical Practice Summaries are based are continually reviewed. You are advised to check the website below for latest versions.


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**Clinical Practice Summary**  
**For Palliative Care Symptoms**

<table>
<thead>
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Introduction and Aide Memoire

These clinical practice summaries are based on the Merseyside and Cheshire Palliative Care Network Audit Group Guidelines. They support decision-making in symptom management and care co-ordination for people with palliative care needs. If there is any doubt regarding clinical decisions for individuals, help should be sought from local Palliative Care services. Details regarding local services can be found at the end of these guidelines.

Ambitions for Palliative and End of Life Care – supporting people in the last weeks of life

All approaches regarding palliative and end of life care should reflect Ambitions for Palliative and End of Life Care, A national framework for local action 2015-2020 and the 6 key principles

- Each person is seen as an individual and
- Receives fair access to care
- We maximise comfort & wellbeing
- Care is coordinated
- All staff are prepared to care
- Each community is prepared to help

Ensure that you have considered the following in communication with the person and those important to them:

- Preferences and possibilities that could constitute an Advance Care Plan
- Sensitive communication about care in the last days of life and decisions about Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Orders
- Ensure that if there is an ICD (Implantable Cardioverter Defibrillator) in place, it has been deactivated.
- Ensure that all relevant Out of Hours services are made aware of any critical documentation e.g. using special note notification and in hospital settings that clear treatment escalation plans are made
- Anticipatory prescribing to relieve common symptoms in the last weeks of life should be considered in a timely manner and individualised to avoid delay in managing distressing symptoms Care of dying adults in the last days of life, NICE guideline NG31

One Chance to Get it Right – Care in the last few days and hours of life

- Recognise deterioration and consider if this is potentially reversible e.g. infection or if the person is likely to die from irreversible causes. Potentially reversible causes should be treated provided that this is in accordance with the person's wishes or in their best interests
- If the person is likely to die from irreversible causes in the next hours or few days communicate this clearly and sensitively
- Involve the dying person and those important to them in day-to-day decisions about personal care and clinical treatments
- Avoid undertaking investigations that are unlikely to affect care in the last few days of life unless there is a clinical need to do so (NG31) e.g. curtailing renal monitoring in advanced heart failure
- Construct an individual plan of care, which includes food and drink, symptom control and psychological, social and spiritual support
- Hydration is not covered in these guidelines but guidance can be found in Care of dying adults in the last days of life, NICE guideline NG31
- Deliver this plan of care sensitively and review frequently especially if symptoms are not controlled, there is concern from family members or the person shows sign of improvement

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Assessment/Description

Malignant bowel obstruction is a recognised complication of advanced pelvic or abdominal malignancy. Common symptoms associated with malignant bowel obstruction include abdominal pain, abdominal colic, nausea and vomiting. The evidence base for management of malignant bowel obstruction is weak and this chapter summarises the best available evidence.

An individualised approach to management is recommended for each patient and specialist palliative care advice should be sought.

- The diagnosis is made clinically through history and examination
- This may be confirmed with imaging (abdominal X-ray or CT scan) depending on individual circumstance and preferences

Medications for Symptom Control in Malignant Bowel Obstruction

**Dose adjustments may need to be made depending on renal and hepatic function**

<table>
<thead>
<tr>
<th>Indication(s)</th>
<th>Drug name</th>
<th>Dose (over 24 hours via CSCI unless otherwise stated)</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relief of constant pain</td>
<td>Opioid via CSCI/24 hours or transdermal Fentanyl patch</td>
<td>Dependent on previous dose</td>
<td>Absorption of oral formulation via gut may have been impaired when converting from oral to CSCI. Consider adjusting the dose accordingly</td>
</tr>
<tr>
<td>Relief of colic</td>
<td>Hyoscine butylbromide</td>
<td>60mg - 240mg</td>
<td>Do not combine with cyclizine in CSCI as can cause crystallisation</td>
</tr>
<tr>
<td></td>
<td>Glycopyrronium</td>
<td>600micrograms - 2.4mg</td>
<td>Does not crystallise</td>
</tr>
<tr>
<td>Reduce volume of gastrointestinal secretions</td>
<td>Octreotide</td>
<td>300micrograms - 600micrograms</td>
<td>Should be considered first line. (If acutely unavailable, use Hyoscine Butylbromide but do not combine with cyclizine in CSCI as can cause crystallisation)</td>
</tr>
<tr>
<td></td>
<td>Hyoscine butylbromide</td>
<td>60mg - 240mg</td>
<td>Do not combine with cyclizine in CSCI as can cause crystallisation</td>
</tr>
<tr>
<td></td>
<td>Ranitidine</td>
<td>100mg - 200mg</td>
<td>Does not crystallise</td>
</tr>
<tr>
<td></td>
<td>Glycopyrronium</td>
<td>600micrograms - 2.4mg</td>
<td>Does not crystallise</td>
</tr>
<tr>
<td>Reduce tumour oedema. Reduce nausea and vomiting</td>
<td>Dexamethasone</td>
<td>8mg subcutaneously od or 4mg subcutaneously bd</td>
<td>Given as a single dose or divided into 2 doses (10am and 2pm or before 12 noon if single dose). Late administration may cause insomnia / agitation</td>
</tr>
<tr>
<td>Reduce nausea and vomiting</td>
<td>Cyclizine</td>
<td>150mg</td>
<td>Do not combine with Hyoscine butylbromide in CSCI as can cause crystallisation</td>
</tr>
<tr>
<td></td>
<td>Haloperidol</td>
<td>1.5mg - 5mg</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Levomepromazine</td>
<td>6.25mg - 25mg</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Metoclopramide</td>
<td>30mg - 90mg</td>
<td>Contraindicated in complete bowel obstruction. Dose may be increased to 120mg/24 hours. Monitor for increased abdominal colic</td>
</tr>
<tr>
<td></td>
<td>Ondansetron</td>
<td>8mg - 32mg</td>
<td>seek local specialist palliative care advice if over 16mg</td>
</tr>
</tbody>
</table>

IMPORTANT CONSIDERATIONS:

Symptom Control

- **Pain:** Opioid analgesia should be titrated to control continuous abdominal pain.
- Colic should be managed with the reduction in dose or discontinuation of prokinetic drugs followed by the commencement of anti-spasmodic medications.

- **Reduction of secretions:** Patients experiencing large volume vomiting should be prescribed anti-secretory medication.
- Octreotide is the recommended first line anti-secretory medication.

- **Reduction of nausea and vomiting:** Anti-emetics should be administered via the subcutaneous route.
- Prokinetics are not advised if the diagnosis of complete vs partial bowel obstruction is uncertain.

Corticosteroids:

- A five day trial of dexamethasone 4mg subcutaneously twice daily morning and lunch should be considered in all patients.

Laxatives:

- The use of stimulant laxatives should be avoided. The use of stool softeners may be appropriate.

Interventions

- **Medication Delivery:** Medication should be delivered via the subcutaneous route due to potential problems with absorption.

Nasogastric Tubes:

- A wide bore nasogastric tube should be considered for patients with upper gastrointestinal obstruction or large volume vomiting.

Venting Gastrostomies:

- Venting gastrostomies or jejunostomies should be considered for patients with malignant bowel obstruction who have a prognosis of greater than 2 weeks.
- Venting gastrostomies have been shown to be cost effective with low morbidity and mortality.

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Assessment/Description
Causes of breathlessness can be multi-factorial: physical, psychological, social and spiritual factors can all contribute to a person feeling breathless. Assessment is vital, particularly in a new presentation. Undertake a history and clinical examination, including oxygen saturations. Investigations such as chest x-ray may be necessary and management will depend on clinical diagnosis. Treat what may be caused by an acute event and reversed, e.g. infection, anaemia, pulmonary oedema etc.

Pharmacological Options:

Opioids: Morphine Oral solution 2.5mg qds and 4 hourly prn. The maximum dose of oral morphine that is likely to be helpful for dyspnoea is 30mg/24 hour period. If patient unable to tolerate oral meds, subcutaneous Morphine Sulphate (1.25mg in opioid naive patients) – 2.5mg 4 hourly prn. If the patient’s eGFR is <30mls/min an alternative opioid should be considered

Benzodiazepines: Lorazepam 0.5mg-1mg SL prn (max dose 4mg in 24 hour period). If patient unable to tolerate oral meds, subcutaneous Midazolam 2.5mg-5mg 4hrly prn. If effective this can be incorporated into a syringe driver over 24 hours

Oxygen: The evidence for efficacy is limited. A trial of oxygen should be considered in patients known to have O₂ saturation less than 90%. Care should be taken in patients with known COPD/Type 2 respiratory failure

Corticosteroids: may help in patients with tumour compression or lymphangitis carcinomatosis. Also can be useful in COPD. No evidence of benefit in non specific dyspnoea. Dose: Dexamethasone 4mg – 8mg daily before 2pm and 8mg twice daily morning and lunchtime in lymphangitis and SVCO

Nebulised Medication: Sodium Chloride 0.9% may help as a mucolytic, 5ml 4hrly prn. Consider a bronchodilator, e.g. Salbutamol 2.5mg 6hrly prn
Causes to consider:

- Drug induced including opioids, diuretics, anti-cholinergics, ondansetron, chemotherapy
- Dehydration: review diuretics and fluid intake
- Reduced mobility
- Hypercalcaemia
- Environmental lack of privacy
- Concurrent disease
- Altered dietary intake
- Neurological
- Intestinal obstruction

Assessment/Description

Constipation is defined by the patient and is a symptom not a disease. The cause of the constipation should be identified and treated, managing bowel obstruction where appropriate.

- History, normal bowel habit, medicines other causative factors.
- Abdominal palpation and auscultation and digital rectal examination.
- Investigation abdominal x-ray, check calcium levels.

Oral laxatives commonly used in palliative care

<table>
<thead>
<tr>
<th>Type of laxative</th>
<th>Drug name</th>
<th>Starting dose</th>
<th>Additional notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Combination laxative</td>
<td>Codanthramer Suspension</td>
<td>5ml-10ml at night</td>
<td>Only licensed for use in terminally ill patients of all ages. May cause abdominal colic.</td>
</tr>
<tr>
<td>Softener laxative</td>
<td>Docusate sodium</td>
<td>100mg tds</td>
<td>Takes 24-48 hours to have an effect. Mainly acts as softener, but doses over 400mg may have weak stimulant action. Syrup is available but the taste is extremely unpleasant.</td>
</tr>
<tr>
<td>Stimulant laxatives</td>
<td>Senna tablets</td>
<td>1-2 tabs at night</td>
<td>Takes 8-12 hours to have effect. May cause abdominal colic.</td>
</tr>
<tr>
<td></td>
<td>Senna syrup</td>
<td>5ml-10ml at night</td>
<td>Reduce dose of senna if colic develops.</td>
</tr>
<tr>
<td></td>
<td>Bisacodyl tablets</td>
<td>1-2 tabs at night</td>
<td></td>
</tr>
<tr>
<td>Osmotic laxatives</td>
<td>Magnesium hydroxide</td>
<td>10ml-20ml bd</td>
<td>Should be avoided in patients with cardiac disease or poor renal function.</td>
</tr>
<tr>
<td></td>
<td>Lactulose</td>
<td>10ml-20ml bd</td>
<td>Can be associated with flatulence/abdominal colic. Can take 48 hours to have an effect.</td>
</tr>
<tr>
<td></td>
<td>Macrogol</td>
<td>1 sachet tds</td>
<td>Macrogol may be used to treat faecal impaction. Give 8 sachets in 1 litre of water, over 6 hours. Contraindicated in complete bowel obstruction.</td>
</tr>
</tbody>
</table>

Rectal interventions for constipation

- Rectal Intervention
- Impacted hard faeces
  - Bisacodyl 10mg suppository plus glycerol 4g suppository plus combination laxative
    - If ineffective use enema
- Impacted soft faeces
  - Bisacodyl 10mg suppository plus oral stimulant
    - If ineffective use enema
- Empty rectum plus loaded colon
  - Use combination laxative plus phosphate enema

Reference

Merseyside and Cheshire Palliative Care Network Audit Group Guidelines
**Initial Treatment**

Assess the likely cause for nausea to guide the anti-emetic most likely to relieve symptoms. Review reversible causes (see box below).

**Patients who become nauseated or start vomiting;**

**Gut causes**

Metoclopramide 10mg tds PO/SC or CSCI 30mg/24 hours *avoid in complete bowel obstruction—see further guidance.*

Domperidone 10mg tds PO.

**Non gut causes (e.g. renal failure, biochemical disturbances, cerebral causes)**

Cyclizine 50mg tds PO/SC or CSCI 150mg over 24hours in water for injection.

Haloperidol 0.5mg – 3mg at night or CSCI 1.5mg to 5mg.

**Alternative anti-emetics may be more appropriate in certain circumstances**

1. **Severe Heart Failure:**

Avoid anti-emetics with anti-muscarinic side effects that may cause tachy-arrhythmias e.g. cyclizine

Levomepromazine 6.25mg s/c pm 8 hourly.

If more than 2 doses required in 24 hours, prescribe levomepromazine 6.25mg to 25mg in CSCI over 24 hours.

2. **Renal Failure:**

Toxicity or metabolic or biochemical cause of vomiting (renal failure, uraemia, hypercalcaemia, medication related)

Use first line medication as above.

Alternatively

Levomepromazine 6.25mg s/c pm 8 hourly—caution, risk of sedation.

If more than 2 doses required in 24 hours, prescribe levomepromazine 6.25mg to 25mg in CSCI over 24 hours.

3. **Parkinson’s Disease/Lewy Body Dementia:**

Avoid anti-emetics with a dopamine receptor antagonist effect e.g. haloperidol, levomepromazine and metoclopramide.

Domperidone first line. Ondansetron can be considered 4mg PO/SC prn.

4. **Raised Intracranial Pressure (ICP):**

If taking oral dexamethasone for symptoms of raised ICP, this should be continued to be given daily via the s/c route.

Aim to maintain at the lowest maintenance dose that controls the symptoms of raised intracranial pressure.

Dexamethasone S/C, 3.3mg to 16mg max daily dose in 1 or 2 divided doses.

All doses of dexamethasone should be given *before 2pm.*

*Dexamethasone can raise blood sugar levels and Capillary Blood Glucose levels should be checked*. If there is a risk of seizures e.g. in brain metastasis, avoid the use of levomepromazine which can lower the seizure threshold.

5. **Gastric Outlet Obstruction/Reflux:**

This can occur due to autonomic neuropathy (paraneoplastic) medication (anti-cholinergics), metabolic causes (e.g. hypercalcaemia), mechanical obstruction.

*If complete bowel obstruction is excluded:* Metoclopramide 30mg-120mg in CSCI over 24 hours.

Avoid the concurrent prescribing of a prokinetic e.g. metoclopramide and an anti-cholinergic (e.g. cyclizine) which will inhibit it’s prokinetic action. Metoclopramide can cause colic.

6. **Bowel Obstruction:**

See chapter on bowel obstruction.

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**Reversible causes of nausea, vomiting or regurgitation to be considered?**

- Anxiety
- Reflux/Gastritis
- Uncontrolled pain
- Cough
- Urinary retention
- Constipation
- Hypercalcaemia
- Oral/oesophageal candidiasis

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**Reference**

Merseyside and Cheshire Palliative Care Network Audit Group Guidelines on Nausea and Vomiting
**PAIN MANAGEMENT**  
**Dose adjustments may need to be made for renal failure**

### COMMON TYPES OF PAIN

- **Visceral / Soft Tissue Pain (nociceptive)**  
  Constant dull pain; Poorly localised  
  Usually opioid responsive

- **Bone Pain (somatic nociceptive)**  
  Usually well localised; Worse on movement;  
  Localised tenderness  
  Partly opioid responsive; NSAID responsive  
  If cancer diagnosis radiotherapy or IV Bisphophonates may help

- **Nerve Pain (neuropathic)**  
  Try opioids first, but may be less responsive  
  Consider adjuvant neuropathic analgesia

###有用的信息

#### Immediate Release Morphine

**Conventional Opioid Titration**

**Immediate Release Morphine (4 hourly duration of action)**

<table>
<thead>
<tr>
<th>Regularly</th>
<th>As Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morphine Oral Solution 2.5mg to 5mg 4 hourly</td>
<td>Morphine Oral Solution 2.5mg to 5mg 1 hourly pm</td>
</tr>
</tbody>
</table>

If clinically frail or eGFR less than 60ml/min/1.73m² use lower doses or reduced regular frequency e.g. regularly 6 hourly to 8 hourly. Assess response of background pain to opioids and if necessary, increase dose by 30-50% every 24-48 hours to achieve pain control.

If eGFR less than 30ml/min/1.73m² see renal failure chapter and guideline

#### Sustained Release Morphine

**Sustained Release Morphine (12 hourly preparation)**

Zomorph capsules bd, MST tablets bd, Morphgesic SR bd, Filnarine SR bd e.g. 5mg morphine used 4 times = 20mg oral morphine in 24 hours = 10mg sustained release morphine (12 hourly) twice a day

When pain controlled on steady dose, convert to sustained release morphine. Add total daily dose of 4 hourly immediate release morphine, and divide by two.

### Pain can be improved for patients. If not improving, seek local specialist advice

#### USE OF TRANSDERMAL OPIOID PATCHES

**Only consider if:**
- Pain is stable, and NOT rapidly changing
- Oral route not appropriate or poorly absorbed in the long term (for short term management consider a continuous subcutaneous infusion (CSCI))
- Unacceptable side effects from other opioids despite opioid rotation, e.g. unmanageable constipation with opioids despite optimisation of laxatives
- Renal impairment (seek specialist palliative care advice in renal failure)

New prescriptions of fentanyl patches are not recommended out-of-hours, unless on specialist advice

**Commencing Patches**

- Titrate with 4 hourly immediate release oral morphine, until pain is controlled
- Remember a fentanyl 25mcg/hour patch is equivalent to a 60mg-90mg total daily dose of oral morphine
- Stick patch to hairless skin; clip (not shave) hair
- Initial analgesic effect will take at least 12-24 hours, and a steady state may not be achieved for 72 hours
- Ensure immediate release oral morphine (or alternative) is available for breakthrough pain
- Change patch every 72 hours; use a new area of skin
- A 12-24 hour depot of drug remains when patch removed; fold in on themselves and discard safely
- Opioid withdrawal may occur when switching from morphine to fentanyl; manage with prn morphine

**Guidance in the Last Days of Life**

- When a patient is dying, leave patch IN SITU, and change as before. Use subcutaneous opioids prn for breakthrough pain; if prn needed regularly, start CSCI in addition to patch
- Ensure prn dose adequate for both patch & CSCI
- Seek Specialist Palliative Care advice for support if need advice

**ADJUVANT ANALGESIA**

- **Co-Analgesics**
- **NSAIDs** (ibuprofen 400mg tds or Naproxen 500mg bd)
- **Neuropathic Agents** (gabapentin 100mg to 300mg nocte or pregabalin 25mg od-bd (starting doses in clinical frailty, requires titration to effects)

**Alternative Opioid Titration**

**Sustained Release Morphine**

(12 hourly duration of action)

<table>
<thead>
<tr>
<th>Regularly</th>
<th>As Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Zomorph capsules 10mg bd or MST tablets 10mg bd</td>
<td>Morphine Oral Solution 2.5mg to 5mg 4 hourly</td>
</tr>
</tbody>
</table>

Assess response of background pain to opioids and if necessary, increase dose by 30-50% every 24-48 hours to achieve pain control – consider Co-analgesics

**Plus Anticipate Opioid Side Effects**

Always co-prescribe regular laxatives  
Senna or Docusate or Co-danthramer or Macrogol and consider prn Anti-emetics E.g. Haloperidol 1.5mg to 3mg PO at teatime

**Prn**  
**Phon**  
**PRN**  
**For Breakthrough Pain**

Sevredol tablets or Morphine Oral Solution can be up to 1 hourly prn if needed

Add total daily dose of background morphine, and divide by six for prn dose

**Plus Immediate Release Morphine (4 hourly preparation)**

When a patient is dying, leave patch IN SITU, and change as before. Use subcutaneous opioids prn for breakthrough pain; if prn needed regularly, start CSCI in addition to patch

**Guidance in the Last Days of Life**

- When a patient is dying, LEAVE PATCH IN SITU, and change as before. Use subcutaneous opioids prn for breakthrough pain; if prn needed regularly, start CSCI in addition to patch
- Ensure prn dose adequate for both patch & CSCI
- Seek Specialist Palliative Care advice for support if need advice

**Reference**

Merseyside and Cheshire Palliative Care Network Audit Group Guidelines on Neuropathic Pain, Symptom Control Medication in the Dying Person, Opioid Substitution, Transdermal Opioids in Palliative Care

SEIZURES

ACUTE SEIZURES
- may settle spontaneously
- ensure airway secure and administer oxygen if available
- If seizure does not stop within 5 minutes give either
  - Intranasal, buccal or subcutaneous midazolam 5mg to 10mg OR
  - Diazepam 10mg-20mg rectally OR
  - Lorazepam 2mg - 4mg intravenously or subcutaneously

IF SEIZURES CONTINUE despite above measures after 15 minutes, if at home/nursing home;
- Repeat dose of the medicine used after 5 minutes.
- Decide if transfer to hospital for emergency management is needed or if care will continue in the current care setting.
- For acute management— A secure airway should be established, oxygen should be administered, cardiorespiratory function should be assessed and intravenous access should be established.
- If patient to stay at home or hospice and two doses needed consider a continuous subcutaneous infusion of midazolam 30mg over 24 hours.

HYPERCALCAEMIA

• Hypercalcaemia is common in cancer of breast, myeloma, lung, head and neck, kidney, thyroid and cervix.
• Primary hyperparathyroidism should be considered as a possible cause (6% of cancer patients).

Presentation:
- Symptoms of hypercalcaemia include: fatigue, weakness, constipation, nausea, vomiting, polyuria, polydipsia, cardiac arrhythmias, delirium, dROWSINESS and coma.

ASSESSMENT:
Clinical assessment of the patient is crucial in determining whether treatment of hypercalcaemia is appropriate. Generally a decision to treat should be motivated by the patient’s symptomatology rather than absolute calcium level. The most important goal of treatment is to improve clinical symptoms.
- Onset of symptoms raising clinical suspicion should be investigated. Bloods should be checked for urea and electrolytes (U&Es), estimated glomerular filtration rate (eGFR), liver function tests (LFT’s) and calcium.
- Corrected serum calcium >2.7mmol/L (some variation between laboratories).

TREATMENT:
- The patient should be rehydrated with 1-3 litres of parenteral sodium chloride 0.9% before the administration of bisphosphonates. The volume and rate of fluid replacement should be adjusted in each patient according to their age, the severity of hypercalcaemia, the degree of dehydration and the ability of the cardiovascular system to tolerate rehydration.
- The treatment of choice is intravenous bisphosphonate— pamidronate, zoledronic acid or ibandronate depending on local formulary choices.
- Corrected calcium levels should be rechecked at 5-7 days after the bisphosphonate infusion. Checking calcium levels prior to this is not appropriate, as the bisphosphonate will not have achieved its maximal effect.

SUPERIOR VENA CAVA OBSTRUCTION (SVCO)

- Compression /invasion or thrombosis of SVCO due to tumour or nodal mass within mediastinum, preventing venous drainage from head, arms and upper trunk.
- Commonest causes (95%) – lung cancer, non-Hodgkin lymphoma.
- Usually onset over weeks or months, but occasionally occurs rapidly.

MANAGEMENT:
“DISCUSS URGENTLY WITH ONCOLOGIST FOR FURTHER ADVICE”
Administer dexamethasone 16mg stat with next daily dose of 8mg twice daily - morning & lunch.
**METASTATIC SPINAL CORD COMPRESSION**

- Affects 5-10% of patients with cancer
- Spinal metastases: most common in prostate, lung, and breast cancer and myeloma
- Catastrophic event – aim is to prevent establishment of paraplegia
- Symptoms may be vague, there should be a high index of suspicion
- Patients with cancer and neurological signs or symptoms of spinal cord compression should be treated as an oncological emergency

**SIGNS:**
Localised spinal tenderness
Weakness of limbs
Reflexes:
- Absent/increased
- Extensor plantar
- Clonus may be present

Altered sensation - look for a sensory level
Distended bladder

**MANAGEMENT:**

**Patient has cancer**

Progressive spinal pain (no neurological symptoms or signs; no neuropathic pain features)

**Known to oncologist/specialist palliative care consultant/site specific team:**
Choose clinician actively managing patient.
Make same day contact with responsible consultant or covering colleague.
Agree management plan to include early MRI.

**Known only to primary health care team**

Make same day contact with previous site specific team/oncologist or seek advice from local specialist palliative care team.
Flag letter ‘SUSPECTED MSCC’ Do not just fax a letter - may cause delay.

**ESCAPING SEVERE SPINAL PAIN OR**
Escaping spinal pain with neuropathic features +/- neurological signs e.g. weakness, sensory loss, bowel/bladder disturbance

**CLINICAL PRESENTATION:**

- Cardiovascular compromise – hypotension, tachycardia (>100bpm = significant recent bleed).
- Identifiable bleeding source – haematemesis, melena, haemoptysis, PV or PR bleeding, haematuria.
- Erosion of an artery by a malignant ulcer or superficial/fungating tumour.

**MANAGEMENT:**

GP medical assessment - same day
History, neurological examination, fitness to treat

Unfit (e.g. poor performance status or no neurological function for >48 hours. Unfit patients with severe pain may still be considered for radiotherapy but do not require an MRI)

GP to admit urgently via local acute medical route to hospital with MRI capability.
Advise patient to remain flat until MRI if possible.
Order ambulance with stretcher to transfer within 2 hours.
Give dexamethasone 16mg orally if available - do not delay admission to prescribe/give. Inform admitting team if given.
Ensure assessing team aware ‘SUSPECTED MSCC’ via letter plus telephone contact if able.

**MAJOR HAEMORRHAGE**

- Bleeding of all types occurs in 14% of patients with advanced disease.
- Haemorrhage causes death in approximately 6% patients.
- Catastrophic external haemorrhage less common than internal bleeding.
- It may be a terminal event in both advanced cancer and non-malignant disease.

**CATASTROPHIC BLEED:**

- Ensure patient is not left alone
- Keep patient warm
- Use anxiolytic or analgesics as needed if the patient is distressed
- Support the patient and family

**CLINICAL PRESENTATION:**

- Catastrophic bleeding: major haemorrhage which is life-threatening
- Usually presents acutely
- Blood loss can be rapid and massive

**MANAGEMENT:**

A member of staff must remain with the patient to provide reassurance at all times

- Plan ahead where possible
- If there are warning signs or high anticipated risk of bleeding have a proposed management plan ideally discussed with patient and/or family and staff
- Record management plan in case notes and communicate this to all team members
- Provide dark coloured towel to disguise blood loss
- Anticipatory prescribing of midazolam 10mg i/v, i.m, buccal or sublingual
- The subcutaneous route should not be used in catastrophic bleeds due to peripheral shut down and therefore unpredictable absorption of the medication

**FURTHER CARE:**

- If bleeding temporarily stops further management will depend on overall clinical status and discussion with patient and family in relation to further acute interventions
- It may be necessary to commence and continue an infusion of anxiolytic (midazolam) or analgesic (e.g. morphine or oxycodone) in the last hours of life
**Assessment/Description**
Patients can’t clear secretions from their upper respiratory tract properly, causing secretions to move as they breathe, creating noise.

**Pharmacological Options:**

**INITIALLY:**
- Hyoscine hydrobromide 400 micrograms sc prn
- Glycopyrronium 200 micrograms sc prn

**ONGOING:**
- Hyoscine hydrobromide 1.2mg to 2.4mg
- Glycopyrronium 600 micrograms to 2400 micrograms
- Hyoscine butylbromide 60mg to 240mg

Seek Local Specialist Palliative Care advice if doses above 120mg of hyoscine butylbromide are needed

- Anti-cholinergic side effects can arise, treat this with frequent mouth care which may include artificial saliva replacement gels or sprays.
- If one agent doesn’t work, try switching to the other after full titration to maximum dose over 24 hours; if there is still no improvement, consider stopping medication.
- If not responding, seek specialist advice as required.

**Non-Pharmacological Options**
- Reposition patient
- Active Surveillance
- Suction
- Reassurance and explanation

**Assessment/Description**
Look for any reversible cause of agitation, and if identified, appropriate management towards it. Consider possible physical, psychological and spiritual factors as well as environmental factors such as lighting and noise.

**Pharmacological Options:**

**INITIALLY:**
- Midazolam 2.5mg - 5mg sc up to 2-4 hourly prn.
  - If eGFR < 30 give a reduced dose of midazolam e.g. 1 mg to 2.5 mg sc prn

**DELIRIOUS:**
- Consider haloperidol 500 micrograms sc 2 hourly prn (monitor for extrapyramidal side effects)

**ONGOING:**
- Haloperidol for agitation 2.5mg to 8mg
- Midazolam for agitation 10mg to 30mg

Seek Local Specialist Palliative Care advice if doses above 30mg of midazolam are needed
- Levomepromazine 12.5mg to 200mg

Seek Local Specialist Palliative Care advice if doses above 25mg of levomepromazine are needed

**Reference**
Merseyside and Cheshire Palliative Care Network Audit Group Guidelines on Symptom Control in the Dying Person
**Assessment/Description**

Syringe drivers are used to administer medication by a continuous subcutaneous infusion (CSCI) over a 24 hours period. They are classed as high risk devices and should only be used by suitably trained clinicians or registered nurses.

**Indications for commencing medication via continuous subcutaneous infusion**

1. Patient is unable to take oral medication
   - Nausea and vomiting
   - Difficulty in swallowing
   - Intestinal obstruction
2. Malabsorption
3. Most effective medicine can only be used via CSCI

### COMMON MEDICINES USED VIA CSCI

#### Anti-cholinergics

<table>
<thead>
<tr>
<th>Drug</th>
<th>Dose Range via CSCI/24 hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hyoscine hydrobromide</td>
<td>1.2mg to 2.4mg</td>
</tr>
<tr>
<td>Glycopyrronium</td>
<td>600 micrograms to 2400 micrograms</td>
</tr>
<tr>
<td>Hyoscine butylbromide</td>
<td>60mg to 240mg</td>
</tr>
</tbody>
</table>

Seek Local Specialist Palliative Care advice if doses above 120mg of hyoscine butylbromide are needed

#### Anti-emetics (See Nausea and Vomiting Chapter for further guidance)

<table>
<thead>
<tr>
<th>Drug</th>
<th>Dose Range via CSCI/24 hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cyclizine</td>
<td>150mg</td>
</tr>
<tr>
<td>Haloperidol for nausea</td>
<td>2.5mg to 5mg</td>
</tr>
<tr>
<td>Ondansetron</td>
<td>8mg to 32mg</td>
</tr>
</tbody>
</table>

Seek Local Specialist Palliative Care advice if doses above 16mg of ondansetron are being considered

<table>
<thead>
<tr>
<th>Drug</th>
<th>Dose Range via CSCI/24 hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metoclopramide</td>
<td>30mg to 120mg</td>
</tr>
</tbody>
</table>

Seek Local Specialist Palliative Care advice if doses above 60mg of metoclopramide are needed

<table>
<thead>
<tr>
<th>Drug</th>
<th>Dose Range via CSCI/24hrs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morphine Sulphate</td>
<td>Doses for all opioids should be calculated based on existing opioid use. If no previous opioid use, seek local specialist advice.</td>
</tr>
<tr>
<td>Diamorphine</td>
<td></td>
</tr>
<tr>
<td>Oxycodone</td>
<td></td>
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<tr>
<td>Alfentanil</td>
<td></td>
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</tbody>
</table>

#### Agitation

<table>
<thead>
<tr>
<th>Drug</th>
<th>Dose Range via CSCI/24 hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Haloperidol for agitation</td>
<td>2.5mg to 8mg</td>
</tr>
<tr>
<td>Midazolam for agitation</td>
<td>10mg to 30mg</td>
</tr>
</tbody>
</table>

Seek Local Specialist Palliative Care advice if doses above 30mg of midazolam are needed

<table>
<thead>
<tr>
<th>Drug</th>
<th>Dose Range via CSCI/24 hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Levomepromazine</td>
<td>12.5mg to 200mg</td>
</tr>
</tbody>
</table>

Seek Local Specialist Palliative Care advice if doses above 25mg of levomepromazine are needed

#### Diluent

All drugs should be diluted with 0.9% saline or Water for Injection. Cyclizine or diamorphine (doses above 40mg) should always be diluted in water for injection.

### Oral Morphine to Subcutaneous Morphine Conversions

- Calculate the total daily dose of morphine in a 24 hour period e.g. 90mgs MST bd = 180mgs
- Divide daily dose of morphine by 2 to give the 24 hour dose of morphine to be infused e.g.
  
  \[
  \frac{180\text{mg}}{2} = 90\text{mg morphine over 24 hours}
  \]
- Breakthrough dose 1/6 of total daily dose of morphine e.g.
  
  \[
  \frac{90\text{mg}}{6} = 15\text{mg morphine}
  \]

Seek local Specialist Palliative Care advice for support if needed
1. NSAIDS should be avoided if possible, unless a patient is already on dialysis and anuric. If an NSAID must be prescribed, the lowest effective dose should be used and the renal function should be re-checked within 5-7 days of starting the drug.

2. If the eGFR is below 30mls/min (CKD 4/5) there is an increased risk of toxic side effects with all opioids due to drug and metabolite accumulation. Opioids should therefore be used with caution and should be monitored on a regular basis. Signs of opioid toxicity may include hallucinations, myoclonus, drowsiness or confusion.

3. When prescribing oral (strong) opioids, the immediate release forms are preferred. Long acting opioid preparations should be avoided (e.g. MST/MXL) as the metabolites accumulate in renal failure.

4. Parenteral Alfentanil or fentanyl are pharmacokinetically the safest analgesics to use in renal failure as the metabolites are non-toxic. The limitations are that they have a very short half life.

5. If a patient requires more than 3 stat subcutaneous doses of a strong opioid, consider starting a continuous subcutaneous infusion of alfentanil.

6. Once a patient is established on a regular stable dose of strong opioid, conversion to transdermal fentanyl may be better tolerated.

### OPIOID ANALGESIA IN END STAGE RENAL DISEASE MANAGED WITHOUT DIALYSIS

<table>
<thead>
<tr>
<th>DRUG</th>
<th>ESRD &lt;15ml/min</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paracetamol</td>
<td>Recommended</td>
<td>Max 3g/24 hrs if GFR &lt;10</td>
</tr>
<tr>
<td>Codeine/Dihydrocodeine</td>
<td>Not recommended</td>
<td></td>
</tr>
<tr>
<td>Tramadol</td>
<td>Use with caution</td>
<td>50mg bd maximum dose</td>
</tr>
<tr>
<td>Morphine</td>
<td>Not recommended</td>
<td>If used, start 2.5mg PO 4-12 hrly (i.e increase time between doses)</td>
</tr>
<tr>
<td>Diamorphine</td>
<td>Not recommended</td>
<td>If used, start 2.5mg sc 4-12 hrly (i.e increase time between doses)</td>
</tr>
<tr>
<td>Buprenorphine</td>
<td>Limited evidence</td>
<td>Use with caution</td>
</tr>
<tr>
<td>Fentanyl</td>
<td>Recommended</td>
<td>Consider reduce starting dose by 25-50%, start prn 25mcg sc 4 hourly</td>
</tr>
<tr>
<td>Alfentanil</td>
<td>Recommended (not prn)</td>
<td>CSCI only. Alfentanil 1mg = Oral morphine 30mg</td>
</tr>
<tr>
<td>Oxycodone</td>
<td>Limited evidence</td>
<td>Use with caution, start 1mg to 2.5mg PO 4-12 hrly</td>
</tr>
</tbody>
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Seek Specialist Advice for People Managed with Haemodialysis or Peritoneal Dialysis

### ADJUVANTS

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<thead>
<tr>
<th>GABAPENTIN</th>
<th>PREGABALIN</th>
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<tr>
<td></td>
<td>eGFR (ml/min)</td>
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<tr>
<td>eGFR (ml/min)</td>
<td>TOTAL DAILY DOSE (mg/day)</td>
</tr>
<tr>
<td>≥80</td>
<td>900 - 3600</td>
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<tr>
<td>50-79</td>
<td>600 - 1800</td>
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<td>30-49</td>
<td>300 - 900</td>
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<td>15-29</td>
<td>150 - 600</td>
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<tr>
<td>&lt;15</td>
<td>150 - 300</td>
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<tr>
<td>≥60</td>
<td>150 - 600 (bd/tds)</td>
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<tr>
<td>≥30 - &lt;60</td>
<td>75 - 300 (bd/tds)</td>
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<tr>
<td>≥15 - &lt;30</td>
<td>25 - 150 (bd/od)</td>
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<tr>
<td>&lt;15</td>
<td>25 - 75 (od)</td>
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**ANTI-EMETICS, SEDATIVES AND ANTI-SECRETORY**

**ANTI-EMETICS:**
- Haloperidol is the drug of choice for nausea in patients with renal failure, but if eGFR is less than 10ml/min the dose should be reduced (250 micrograms to 500 micrograms PO or SC).
- Levomepromazine is a useful alternative anti-emetic.
- Cyclizine should be avoided due to the risk of hypotension / tachyarrythmias.
- Metoclopramide should be avoided due to the increased risk of extrapyramidal reactions.

**SEDATIVES:**
- Midazolam metabolites accumulate in renal failure. Patients may be more sensitive to the effects of midazolam. The lowest effective dose should be used.
- Uraemia may cause or contribute to agitation in the dying phase.
- Consider the use of Haloperidol if the patient is suffering from delirium rather than agitation/anxiety.

**ANTI-SECRETORY:**
- Glycopyrronum is the drug of choice for managing secretions. It accumulates in renal failure and a dose reduction of 50% is recommended i.e 100 micrograms SC prn.
- Hyoscine hydrobromide has an increased risk of causing drowsiness and paradoxical agitation.

---

**ANTI-DEPRESSANTS**

Prevalence of depression high in those with CKD 5 (14-30%)

Unclear whether anti-depressants are effective in CKD 3-5 - limited evidence, there is some evidence from small trials showing SSRI’s safe in advanced CKD/ESRF

Drug pharmacokinetics of anti-depressants are altered in renal impairment
- Fluoxetine and Citalopram need no dose adjustment
- Mirtazapine - start at 15mg, increase carefully
<table>
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<th>LOCAL INFORMATION</th>
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<td>Important information for locality</td>
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<tr>
<th>Local Chemists (Out of hours)</th>
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